Identifying and Measuring Risk for Homelessness Among Veterans

HSR&D IIR-13-334

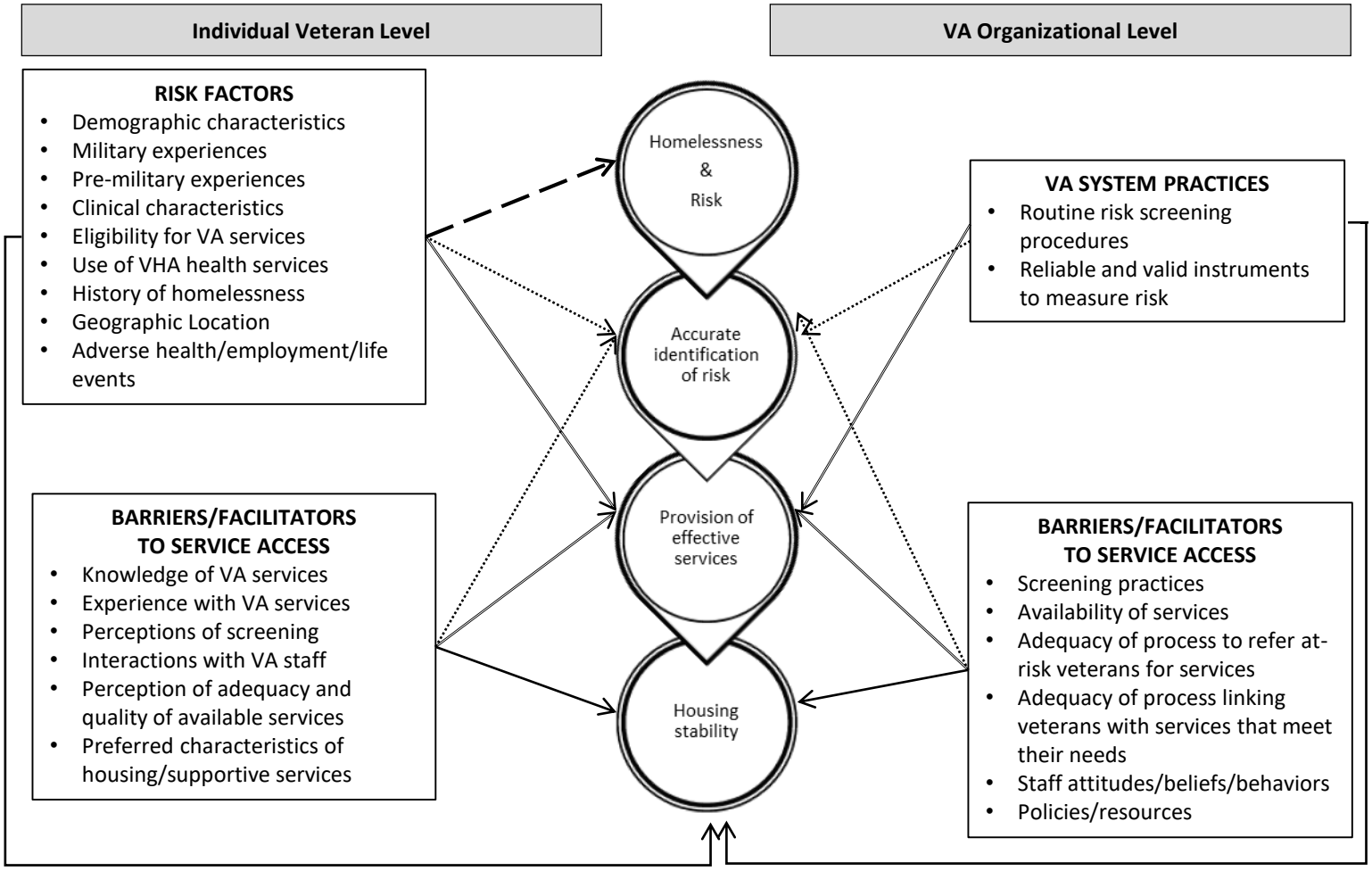
Homelessness Screening Clinical Reminder (HSCR)

- In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?
  - No → current housing instability

- Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household?
  - Yes → risk of housing instability

- Veterans screening positive to either question are then asked:
  - Where they have lived for most of the previous 2 months
  - Whether they want to be referred for social work or housing-related services

Conceptual Model



Specific Aims

1. To validate the HSCR and assess risk factors for current homelessness and imminent risk of homelessness among Veteran users of VHA healthcare services

2. To assess the effectiveness of the HSCR at linking Veterans who screen positive for homelessness or risk with subsequent services

3. To evaluate the psychometric properties and efficacy of 2 existing instruments used by the SSVF program—the SSVF Instrument and the HRA—to quantify risk of homelessness among Veterans

Aim 1a

To evaluate the predictive validity of the HSCR

Prevalence

- 5,771,496 Veterans responded to HSCR during FY 2013–2014

- Positive screens
  - Current housing instability: 0.8% (n=45,282)
    - 61.9% were living in a homeless situation
    - 24.5% were in a housed situation

  - Risk of housing instability: 1.0% (n=54,882)
    - 25.1% were living in a homeless situation
    - 65.3% were in a housed situation

- Negative screens
  - 98.2% (n=5,671,332)

Prevalence

	Group 1: Housing Instability N=45,282 (0.8%)	**Group 2: Risk of Housing Instability N=54,882 (1.0%)**	**Total**
Living Situation			
Homeless	27,878 (61.9%)	13,768 (25.1%)	41,646 (41.5%)
Friend/Family	18,355 (40.8%)	12,720 (23.2%)	31,075 (31.1%)
Shelter	2,091 (4.6%)	177 (0.3%)	2,268 (2.3%)
Street	4,791 (11.0%)	307 (0.6%)	5,278 (5.3%)
Motel/Hotel	2,461 (5.5%)	564 (1.0%)	3,025 (3.0%)
Non-Homeless	11,106 (24.5%)	35,843 (65.3%)	46,949 (46.8%)
Subsidized Housing	971 (2.2%)	3,110 (5.7%)	4,081 (4.1%)
Unsub. Housing	9,179 (20.4%)	32,395 (59.0%)	41,574 (41.6%)
Institution	866 (1.9%)	338 (0.6%)	1,204 (1.2%)
Unknown	6,127 (13.6%)	5,269 (9.6%)	11,396 (11.4%)

Administrative Evidence of Homelessness

- Administrative evidence for homelessness significantly varied depending on whether Veterans accepted or declined a referral for services
  - 61.3% of Veterans who screened positive for housing instability and accepted services had administrative evidence of homelessness
  - 19.0% of those who declined had administrative evidence of homelessness ($p<.01$)

Administrative Evidence of Homelessness

	Group 1: Housing Instability N=45,282 (0.8%)	**Group 1a: Homeless Living Situation N=27,878**	**Group 1b: Non-Homeless Living Situation N=11,106**	**Group 2: Risk of Housing Instability N=54,882 (1.0%)**	**Group 3: Negative N=5,671,332 (98.2%)**	**Total**
Accepted Referral for Service	28,279 (65.6%)	18,073 (67.9%)	6,664 (62.4%)	31,868 (60.5%)		60,147 (62.8%)
Administrative Evidence of Homelessness	21,502 (47.5%)	14,444 (51.8%)	4,017 (36.5%)	12,129 (22.1%)	43,955 (0.8%)	77,586 (1.3%)
If Accepted Referral	17,336 (61.3%)	11,755 (65.0%)	3,381 (50.7%)	10,054 (31.5%)		27,390 (45.8%)
If Declined Referral	2,922 (19.0%)	1,994 (23.3%)	453 (11.6%)	1,462 (7.0%)		4,384 (12.3%)

Summary

- The HSCR differentiates between homelessness and risk of homelessness
- A positive HSCR screen leads to a referral for services in majority of cases

Gaps & Questions

- 11,020 Veterans removed from sample because they reported receiving housing assistance
  - What is overlap with VHA Homeless Program use? May provide some indication of mainstream vs VHA services use.
- 56,356 Veterans removed from sample because they participated in VHA Homeless Program 6 months pre-HSCR
  - How did these Veterans screen? Data may be used to validate HSCR responses.
- 43,955 Veterans screened negative but had administrative evidence of homelessness post-HSCR
  - Do false negatives "look" different in terms of characteristics, services use? How do they compare with Veteran who were not screened based on previous VHA Homeless Program use?
- Why do 1/3 of Veterans who screen positive decline to speak with someone further about their housing situation?
  - Consider these results along with Aim 2a analyses about connection with services and how this may vary by provider type; could indicate some lack of documentation of services receipt.
- What is the gold standard for measuring homelessness in VHA data?

References

Presentations

Fargo, J., Montgomery, A. E., Byrne, T., Brignone, E., Cusack, M., & Gundlapalli, A. V. (2017 April). Needles in a haystack: Healthcare system evidence for homelessness. Informatics for Health 2017, Manchester, UK.

Publications

Fargo, J. D., Montgomery, A. E., Byrne, T. H., Brignone, E., Cusack, M. C., & Gundlapalli, A. V. (2017). Needles in a haystack: Screening and healthcare system evidence for homelessness. Studies in Health Technology and Informatics, 235, 574–578.

Aim 1b

To identify risk factors for homelessness and risk among Veteran uses of VHA healthcare

Veteran-Level Risk Factors (Sociodemographics)

	Homeless	Risk	Repeat Positive (any type)	Repeat Homelessness	Unsheltered Homelessness
Female Sex	**+**	**-**	**-**	**-**	**-**
Late Baby Boomer birth cohort	**+**	**+**	**+**	**NS**	**+**
Black/African American race	**+**	**+**	**+**	**+**	**-**
Not married	**+**	**+**			
OEF/OIF	**+**	**+**	**NS**	**NS**	**-**
No service connected disability	**+**	**+**	**+**	**+**	**+**

NOTES:

- +/- indicates direction of association in multivariate analyses
- NS indicates lack of significant finding
- Gray shading indicates not studied

Veteran-Level Risk Factors (Health Conditions)

	Homeless	Risk	Repeat Positive	Repeat Homelessness	Unsheltered Homelessness
Any chronic health					-
Hypertension	-	**NS**			
Diabetes	-	+			
COPD	+	+			
Obesity	-	**NS**			
TBI	**NS**	**NS**			
PTSD	+	+			
Depression	+	+			
Psychosis	+	+			
Alcohol abuse	+	+			+
Drug abuse	+	+			+
Suicide attempt	+	+			

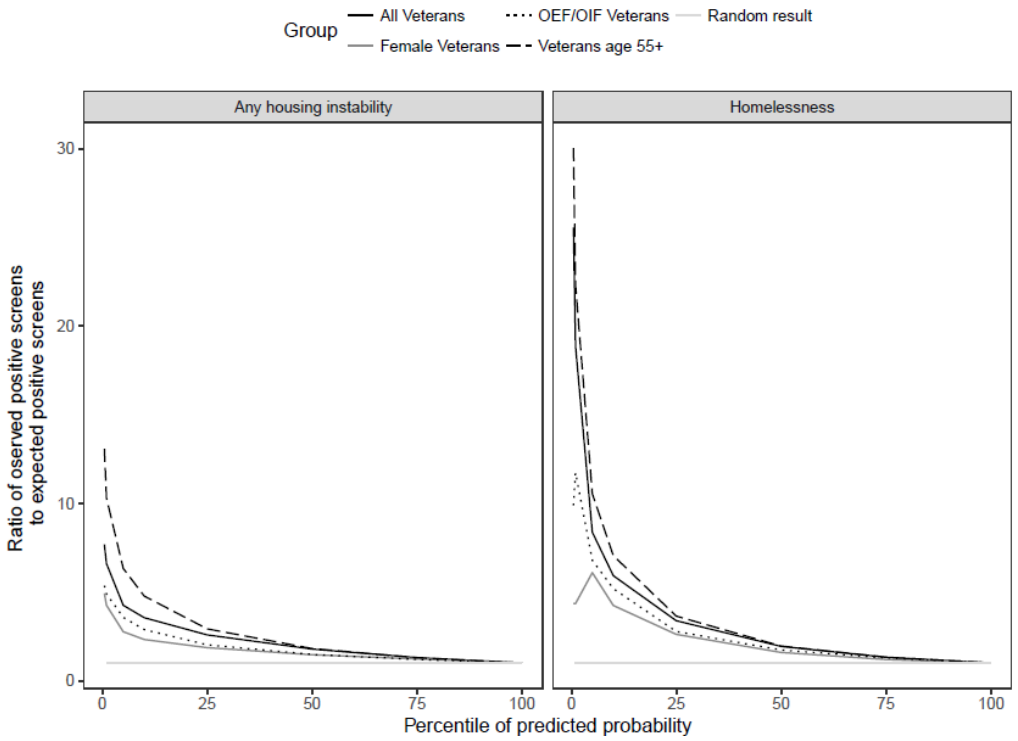
Contextual Risk Factors

	Homeless	Risk	Repeat Positive	Repeat Homelessness	Unsheltered Homelessness
Unsheltered at initial screen				+	
Screened in mental health clinic (v. primary care)	+	+	+	+	NS
Screened in substance abuse (v. primary care)	+	+	+	+	NS
Screened in rural facility	-	-	NS	-	-
Accepted referral			+	+	
Western region (v. Northeast)	+	+	+	+	+

Predictive Models: How well can risk factors predict risk?

How to use predictive models?

- Targeted screening: Could cut in half # of Veterans screened and still identify 90% of all Veterans who screen positive
- Risk stratified modifications: Less/more frequent screening
- Engage high risk Veterans:
  - Embed model-predicted risk scores in EMR and alert clinicians and give them info about referrals
  - Proactive outreach to high risk Veterans



Summary

- Some characteristics are consistently risky
  - Late Baby Boomer birth cohort
  - Black/African American race
  - Unmarried
  - No service-connected disability
- Inconsistent relationship between chronic health conditions and housing outcomes; strong and consistent relationship between behavioral health conditions and housing outcomes
- Predictive models do a fairly decent job of predicting risk

Gaps & Questions

- Service-connected disability status is consistently protective and potentially mutable; what would be a policy recommendation?
- What does the relationship between health conditions and housing outcomes mean? Do these represent pathways to homelessness (e.g., health conditions make employment impossible)?
- Would be good to know more about mutable (and especially situational) predictors:
  - Income level
  - Employment status and/or recent job loss
  - Sudden health problems
  - Eviction
  - Recent release from incarceration
  - Relationship dissolution
- Can the predictive model also be used to identify false negatives?
- Can HRA data be used to assess improvement in performance of predictive modeling after including variables (such as those listed above) that are not in VHA medical record data?

References

Presentations

Byrne, T. (2015 September). Identifying and measuring risk for homelessness among veterans: Evidence from the U.S. Department of Veterans Affairs. Presented at the Boston University School of Social Work Research Seminar Series, Boston, MA.

Byrne, T. (2017 June). New Findings from Ongoing Research with the VA's Homelessness Screening Clinical reminder. Presented at the National Coalition for Homeless Veterans Annual Conference, Washington, DC.

Byrne, T. H., Fargo, J. D., & Montgomery, A. E. (2017, June). Predictive modeling of homelessness and housing instability in the Veterans Health Administration. Poster presentation at AcademyHealth 2017 Annual Research Meeting, New Orleans, LA.

Byrne, T. H., Montgomery, A. E., & Fargo, J. D. (2017, November). Predictive modeling of homelessness and housing instability in the Veterans Health Administration. Oral presentation at 145th American Public Health Association Annual Meeting & Exposition, Atlanta, GA.

Byrne, T., & Montgomery, A.E. (2015 July). Characteristics and likelihood of ongoing homelessness among unsheltered veterans. Presented at the National Alliance to End Homelessness National Conference on Ending Homelessness, Washington, DC.

Byrne, T., Nelson, R.E., Montgomery, A.E., Brignone, E., Gundlapalli, A. & Fargo, J.D. (2017 January). Comparing the Utilization and Cost of Health Services Between Veterans Experiencing Brief and Ongoing Episodes of Housing Instability. Presented at the Society for Social Work Research Annual Conference, New Orleans, LA.

Montgomery A. E. (2016 June). Screening for homelessness. Presented at the National Coalition for Homeless Veterans Annual Conference, Washington, DC.

Montgomery, A. E., Byrne, T. H., Fargo, J. D., Treglia, D., & Culhane, D. P. (2017, June). Unsheltered homelessness among Veterans accessing healthcare at the U.S. Department of Veterans Affairs. Poster presentation at AcademyHealth 2017 Annual Research Meeting, New Orleans, LA.

Montgomery AE, Byrne TH, Fargo JD, Treglia D, Culhane DP. (2016 August). Novel research identifying increased risk factors for homelessness in US Veterans: Unsheltered homelessness among Veterans accessing outpatient care at the VHA. Symposium at the 2016 American Psychological Association Annual Convention, Denver, CO.

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Montgomery, A. E., Byrne, T. H., Treglia, D., & Culhane, D. P. (2016). Characteristics and likelihood of ongoing homelessness among unsheltered Veterans. Journal of Health Care for the Poor and Underserved, 27, 911–922.

Montgomery, A. E., Dichter, M. E., Thomasson, A. M., Fu, X., & Roberts, C. B. (2015). Demographic characteristics associated with homelessness and risk among female and male Veterans accessing VHA outpatient care. Women's Health Issues, 25(1), 42–48.

Montgomery, A. E., Dichter, M. E., Thomasson, A. M., Roberts, C. B., & Byrne, T. H. (2015). Disparities in housing status among Veterans with general medical, cognitive, and behavioral health conditions. Psychiatric Services, 66(3), 317–320. doi:10.1176/appi.ps.201400014

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Montgomery, A. E., Sorrentino, A., Cusack, M. C., Bellamy, S. L., Medvedeva, E., Roberts, C. B., & Dichter, M. E. (2018). Recent intimate partner violence and housing instability among women veterans. American Journal of Preventive Medicine, 54(4), 584-590.

Works in Progress

Byrne, T. H., Montgomery, A. E., & Fargo, J. D. (under review) Predictive modeling of housing instability and homelessness in the Veterans Health Administration. Submitted to Health Services Research.

Aim 2a

To assess the extent to which Veterans who screen positive for current homelessness or risk (1) accept or refuse referral to social work or homeless services; (2) receive services following referral; and (3) participate in specific interventions

Receipt of Services: Previous Work

Women

- Homeless
  - Unmarried
  - Depression
  - Psychosis
  - Requested referral
- At Risk
  - Depression
  - Psychosis
  - PTSD
  - Requested referral

Men

- Younger age
- Unmarried
- NSC/Medicaid-eligible
- Rural (homeless only)
- Any health condition
  - Alcohol abuse
  - Drug abuse
  - Depression
  - Psychosis
  - Schizophrenia
  - PTSD
  - Suicide/self-harm
- Requested referral

Screening & Homeless Experience

Variable	Reference	Accepting Referral	Receiving Services
Screening response: At risk	Homeless	-	-
Accepted referral	Declined referral		+
Provider administering screener	Physician		
Behavioral Health/Social Work Provider		-	+
Nurse Practitioner/Physician Assistant		NS	+
Nurse		NS	+
Multiple/Other		-	+
History of homelessness 24 months pre-screening	None		
Assessment		NS	NS
GPD		NS	+
HCHV/other		NS	+
HUD-VASH		+	+
Outpatient/inpatient stop code		+	+
SSVF		+	+
Social work		+	+

Variable	Reference	Accepting Referral	Receiving Services
Clinic type where screening administered	Primary Care		
Behavioral health		-	NS
Substance use		-	NS
Other		NS	+
Current living situation	House – no subsidy		
House-subsidy		NS	NS
With friend/family		+	+
Motel/hotel		+	+
Institution		-	+
Homeless shelter		+	+
Street		+	+
Other		-	+

Demographics, Military Service & Diagnoses

Variable	Reference	Accepting Referral	Receiving Services
Demographics			
Age	18-34		
35-44		NS	-
45-54		NS	-
55-64		-	-
65+		-	-
Female	Male	NS	NS
Race	White		
Black		+	+
Other		+	+
Ethnicity: Hispanic	Non-Hispanic	-	NS
Marital status: Unmarried	Married	+	+
Rural		NS	-
Region	West		
Northeast		-	NS
Midwest		NS	NS
South		NS	NS
Enrollment Priority Group	NSC, VA pension		
NSC		-	-
Other		NS	NS
SC < 50%		-	-
SC >= 50%		-	-

Variable	Reference	Accepting Referral	Receiving Services
Military Service			
Combat experience		-	NS
MST		+	+
OEF/OIF		-	+
Service component	Army		
Air Force		-	NS
Coast Guard/Other		-	NS
Marine Corps		-	NS
Navy		-	NS
Diagnoses			
Chronic medical condition		-	-
Depression		NS	-
PTSD		-	-
Schizophrenia		-	-
Other psychoses		-	NS
Suicide or self-harm		+	+
Alcohol use disorder		NS	+
Drug use disorder		NS	+

Summary

- Relationship between screening experience and connection with services
  - Provide training on appropriate referral/services linkages
  - Shift responsibilities to staff who may be better equipped to respond to positive screens
  - Develop consult package that mimics clinical applications
- Increased odds of connection with services among Veterans currently in homeless living situation
- Increased odds of connection with services among Veterans with a history of VHA Homeless Program use
- Mixed results around sociodemographics and health-related conditions
  - Responses should be sensitive to issues such as stage of life course, recent reintegration, lack of social support, experience of trauma

Gaps & Questions

- To what extent do Veterans who screen positive for current homelessness or risk participate in specific interventions?
- What can we learn from rescreens?
  - Is the 6 month/1 year/2 year timing guideline useful?
  - What accounts for resolution of homelessness or risk (based on rescreens) and what factors are associated with repeated homelessness or risk?
  - What is the time to receive services following positive screens and associated factors (based on repeated screens)?

References

Papers

Montgomery, A. E., Dichter, M. E., Thomasson, A. M., & Roberts, C. B. (2016). Services receipt following Veteran outpatients' positive screen for homelessness. American Journal of Preventive Medicine, 50(3), 336–343. doi:10.1016/j.amepre.2015.06.035

Works in Progress

Mixed methods paper assessing the role of the screening experience on access to services

Aim 2b

To explore, through qualitative interviews with Veterans, factors that lead to a positive screen, reasons for acceptance or refusal of a referral to social work or homeless services, and preferred characteristics of supportive services

What does the HSCR measure?

- Strong and significant relationship between common risk factors for housing instability (e.g., temporarily living with friends/family, two or more moves during the previous year, imminent eviction) and a positive screen for homelessness or risk

- However, among 45,282 Veterans who screened positive for homelessness over a 3-year period, only 15% met the strictest criteria for literal homelessness (i.e., living in a shelter intended for people experiencing homelessness or an unsheltered location), and only 2 of 5 requested assistance to address their housing

Veteran Participants – Qualitative

- Only 16.7% recalled being screened

Screening Group	% Accepted Referral	% Declined Referral
Homeless (n=30)	70.0	30.0
At-risk (n=30)	76.7	23.3

- Based on qualitative narratives, they experienced a variety of housing conditions

Housing History	%
Never experienced homelessness	8.3
Housing instability but no homelessness	55.0
One episode of literal homelessness	20.0
Multiple episodes of literal homelessness	16.7

Veteran Participants – Qualitative

- Reported a range of financial situations
  - Can't make ends meet – 30.0%
  - Between can't make ends meet and just enough – 5.0%
  - Just enough to get along – 55.0%
  - Comfortable – 10.0%

- Nearly all reported at least one mental health condition
  - Depression – 95.0%
  - PTSD – 66.7%
  - SUD – 56.7%
  - MST – 26.7%
  - TBI – 21.7%
  - Schizophrenia – 11.7%

Veteran Perspectives on the HSCR

- Elements of stable housing
  - Affordability
  - Permanence
  - Comfort and safety
  - Structural and functional adequacy

- Threats to housing stability
  - Uncertain finances
  - Volatile nature of much available housing
  - Personal stressors, such as a chronic medical conditions or issues related to substance use

Affordable

- *Stable housing is when you month-by-month pay your rent…You do not have to worry about [someone] saying "get out…" unless you do not pay your bills.*

- *You have to be able to heat your home. You have mortgage payments, car insurance payments, food. There are a lot of things that play into stable housing.*

Permanent

- *You are in a housing situation that…you are stable and you are not **worried** about being evicted or kicked out by the people you live [with].*

- *I'm welcome to stay there as long as I want. I'm not really **worried** about having to get out.*

- *I think a place that you can feel secure, that you don't have to **worry** about being evicted.*

Comfortable & Safe

- *I think, "have I had somewhere to go and relax, somewhere where I feel a safe haven?"…A safe haven is a place where you can close your door to the world. You can go and do what you want to do…private, somewhat secure.*

- *For me, the idea of safety is ensuring that I'm not watching over my shoulder when I'm getting out of my car…I can park my car at night and ensure that nothing's going to happen to it. I can walk around the block and not worry about if somebody's going to hit me in the head and try to steal my purse.*

Structurally & Functionally Adequate

- *Maybe "livable" would be a better term to use because stable means you're making ends meet…Livable would be more concrete…Because I'm sure people rent apartments and have bugs and stuff, especially in the city. I've got so many roommates that have to deal with their own issues in their own apartments and they call it stable, but is it livable?*

- *Stable: safe, secure, where you have running water, where you have heat, where you have access to food and bathroom and you have a bed to sleep in.*

Uncertain Finances

- *I think of situations where someone might not have enough money because they are living off disability. And, to be quite frank, disability is not a lot of money to live off of, especially with how rents have increased, utilities have increased, and the cost of food…A lot of people are really one rent receipt away from homelessness.*

- *Anything can happen within two months. I think your situation could change significantly. You may not be able to afford to stay where you are at or circumstances may come and you might [lose your housing].*

Volatile Nature of Available Housing

- *We're just one argument away. That's how I feel…And it weighs on my mind constantly.*

- *I am afraid that I might be homeless because…where I am renting from, the owner of the home is behind a few years in taxes. I keep seeing mail coming in stating that the home is going to be on a Sheriff's sale if they do not pay the taxes. So, I am very afraid of that.*

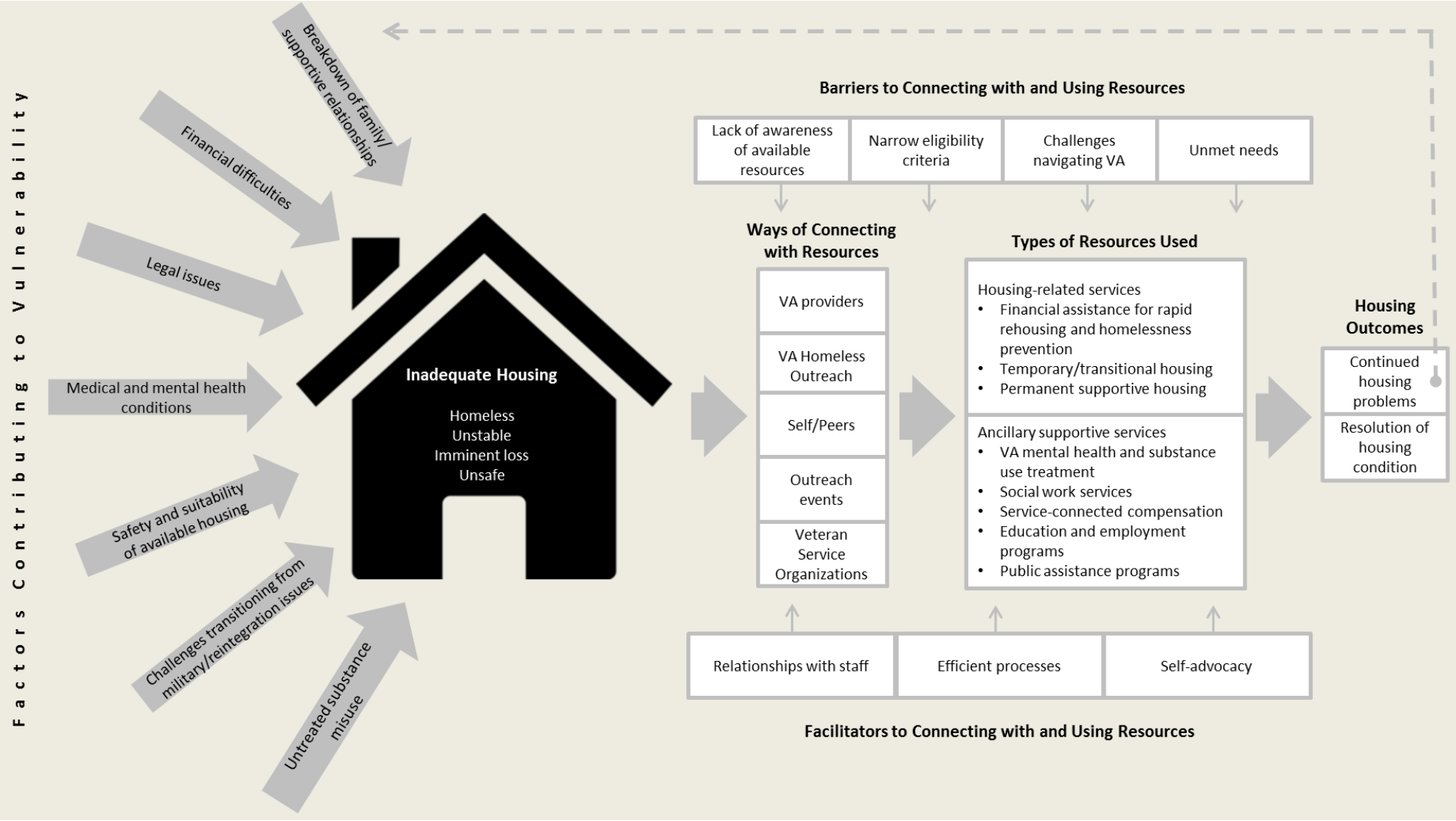
Personal Stressors

- *I could not even sustain myself with my income. I have not worked in 5 years. My Social Security Disability is pending. I have a lot of illnesses that I am dealing with. I take a lot of medications. I cannot work anymore.*

- *So many mental health concerns…that might cause them not to have a stable environment or home for the next 2 months…Or just being able to comprehend how to take care of themselves and pay their rent and make sure these things are taken care of.*

- *I know I have money coming in from [Social Security Disability] and the VA that, as long as I do not blow it on drugs and alcohol, I will be able to pay my rent, but that is always an issue for me because of my addiction…So stability has to do with being able to pay the rent and doing the right thing so I have the money to pay the rent.*

Journey to Home Conceptual Model



Factors Contributing to Vulnerability

- *I lost my car, I lost my job. It's just every, it's like a domino effect. Everything—once the one pin fell, everything fell apart.*

- *It was medical issues; it was family issues; it was life. At the same time I left my job because of my feet, everybody was dying on me. My uncle died and then six months later, my aunt, his wife. Then about six months after that, my grandmother. Then I got diabetes. Then when I got my ACL, AC-1 fixed so I can have surgery. Then my mother passed right before surgery. Then I had surgery. Two surgeries in, my aunt passed.*

Ways of Connecting with Resources

- *I just so happened to walk past an office that said "Homeless Veterans." And I'm like, "Are you kidding me?" And I entered that office and found out about HUD-VASH. And at that time, it seemed like a miracle or the light towards the tunnel. Everything was there.*

- *I used to always go out [to the Stand Down] because they have clothes and stuff like that and you could find out what kind of benefits you're getting. You can get a little medical checkup. And, you can always talk to other Vets…because they really don't tell you benefits you can get and everything. So, you talk to other Vets who know…and pass the information around.*

Housing-Related Resources

- *I think that was what I needed, the first, last,…that's $2,100. I don't have $2,100. I don't have a job right now, so it's hard for me to build up $2,100 to move into a place and still be able to feed myself, take care of myself, and do all the things I need to do.*

- *For the past two months I've been living in [a transitional housing program]. It's stable. I pay 30 percent of my income for rent. It's a stable environment. I'm able to make my appointments. I'm having counseling, [Alcoholics Anonymous, Narcotics Anonymous]…One of the goals is that we get healthy, get an income, and get permanent housing.*

Ancillary Supportive Services

- *We had three good men: Mr. Medicaid, Mr. Section 8, and…[Mr.] Food Stamps...It's the most reliable men that you'll ever have…You only have to go in and tell all of your business with him, go in and show him what color your panties are once a year because they would've asked all the details. But the thing is, if you're smart when you're on these particular programs, you go to school. That's what I did. You go to school. You have little odd jobs, you know, whether you're doing housekeeping on the side or something. You go to graduate, so you can get a job.*

Barriers

- *The most [important] thing is [Veterans] have to know where to go get the housing help from. And, sometimes it's hard to find out.*

- *I actually have to be in a homeless shelter or be in the street for them to actually help me. I did not want to hit rock bottom to get help. That is the only way I can get help, it seemed like, by hitting rock bottom.*

- *You seem like, really, you want to help, but what good is it going to do me if you pay three months and you put me in a place? What am I going to do in the fourth month?*

Additional Services Requested

- Help with transportation
- Assistance finding long-term employment
- Computer access
- Financial assistance for homeowners (e.g., funds for back taxes, mortgage assistance, and/or assistance with refinancing properties in foreclosure)
- Access to a full range of medical benefits (e.g., eye care)
- Resources to keep Veterans in housing
- Peer support
- Housing options not limited to men/specific to women

Facilitators

- *If you do not have the contacts, it is very hard to get help…To get stable housing, you have to know where to go, you have to…have a social worker that can inform you of all the benefits…I did not know the social worker was this important.*

- *With the VA, it seems like they do not want to help you unless you actually force them…For me to get help here for my drug addiction, I had to fight with them every single day…I advocated for myself. I got myself the therapy. I got myself into the [Addiction Recovery Unit]. I did everything.*

Housing Outcomes

- *We went into the leasing office and to go look at the apartments there. The next thing you know, I was like okay, so what do you want me to do? He said: "Nothing. This is your apartment"...After they all left there, I started jumping up and down, and screaming and hollering. Then I laid right down on the floor like a little baby. I took my coat and spread it out. I laid down there and laid by the curtain because the sun was coming in. I went to sleep.*

Implications

- Recognize the full range of Veterans' vulnerabilities
  - Assess full range of medical, mental health, substance use, and social work needs when addressing social determinant of health
  - Respond to threats to housing stability
    - Connections to benefits and employment programs, increase financial literacy, and provide legal assistance and landlord-tenant mediations
- Address inadequate housing through appropriate resources and services
  - Address housing affordability, permanence and safety
    - SSVF. HUD-VASH
  - Create a "home"
    - Project-based housing, move-in assistance
  - Remove barriers (e.g., lack of awareness) and address challenges to navigating resources (e.g., encourage relationships with staff, improve processes)

Summary

- When responding to the HSCR, Veterans are considering a multi-faceted understanding of housing stability

- Need to recognize the full range of Veterans' vulnerabilities
  - Assess medical, mental health, substance use, and social work needs when addressing social determinant of health
  - Respond to threats to housing stability
    - Connections to benefits and employment programs, increase financial literacy, and provide legal assistance and landlord-tenant mediations

- Address inadequate housing through appropriate resources and services
  - Address housing affordability, permanence, and safety (SSVF, HUD-VASH)
  - Create a "home"
  - Remove barriers (e.g., lack of awareness) and address challenges to navigating resources (e.g., encourage relationships with staff, improve processes)

Gaps & Questions

References

Presentations

Montgomery, A. E. (2017, August). Practical considerations for index development: Measuring risk for homelessness. Collaborative Expert Roundtable: Creating a Housing Insecurity Survey Module at U.S. Department of Housing and Urban Development, Office of Policy Development and Research, Washington, DC.

Montgomery, A. E., & Culhane, D. P. (2018, May). Housing permanency. Workshop session at the 2018 National Coalition for Homeless Veterans Annual Conference, Washington, DC.

Publications

Fargo, J. D., Montgomery, A. E., Byrne, T. H., Brignone, E., Cusack, M. C., & Gundlapalli, A. V. (2017). Needles in a haystack: Screening and healthcare system evidence for homelessness. Studies in Health Technology and Informatics, 235, 574–578. doi:10.3233/978-1-61499-753-5-574

Montgomery, A. E., Fargo, J. D., Kane, V., & Culhane, D. P. (2014). Development and validation of an instrument to assess imminent risk of homelessness among Veterans. Public Health Reports, 129, 439–447. doi:10.1177/003335491412900506

Works in Progress

Cusack, M. C., Montgomery, A. E., Sorrentino, A. E., Dichter, M. E., Chhabra, M., & True, J. G. Journey to home: Development of a conceptual model to describe Veterans' experiences with resolving homelessness and housing instability.

Montgomery, A. E., Cusack, M. C., Chhabra, M., Sorrentino, A. E., Dichter, M. E., & True, J. G. Assessing the meaning of housing instability among Veteran outpatients: "I just think it's tight, it's right, it's good, it's what you want."

Aim 2c

To identify, through key informant interviews with VHA social workers, ecological factors that impact their ability to effectively link Veterans who screen positive with available services

Connecting Veterans with Post-Screening Services

- Clinician enters consult (key informants note: “you hope they captured Veteran’s contact information and you hope that it is right”)
- Someone on homeless outreach team checking every day for consults
- Attempt to contact Veteran within 24 hours; at least 3 attempts before closing out the consult
- Veteran is provided with resources over the phone, or comes in for in-person meeting
- *We tried to clarify the consults. We added our own questions maybe in the first month after this started. And if they [Veterans] say they don’t have their own place, I think that triggers the provider to put in the consult.*

Barrier: Lack of Clinician Training & Knowledge

- No formal training for providers:
  - Clinicians do not always include contact information to facilitate followup
  - Lack of knowledge about what outreach staff do, who they serve, and what resources they have access to
  - Clinicians send Veterans to homeless outreach for concerns unrelated to housing and for benefits that aren't available (transit tokens)
- VAMC has practice of sending any Veteran with need of transportation, lunch, clothing, money, utilities – "go upstairs to homeless outreach"

HSCR Effectively Identifies & Connects Literally Homeless Veterans

- Because HSCR is completed during visit, VA homeless outreach team often able to connect with Veterans who screen positive before they leave medical center
- Enables VA to identify and connect Veterans who receive primary care at VA and who might not otherwise be identified;
  - *Especially with people who only see primary care and do not ever really engage in any other services in the hospital. … the social network of veterans, especially those who are chronically homeless, that [primary care] is probably the strongest network in that they know where to go and who to talk to… in terms of reaching people who do not otherwise connect with any sort of our access points [the HSCR has helped], absolutely.*

Screening Has Unintended Effects

- Perception that HSCR yields many false positives (~50%)
  - *Maybe half of the consults are legitimate, more or less.*

- Changes process of identifying and connecting Veterans from 'outreach' to 'in-reach'—Challenging to allocate resources, may impede ability to do outreach on the streets
  - *It kind of seizes your ability to go out and do street outreach when you are having a big inflow of people at the hospital. Which is not necessarily a bad thing, it is just trying to allocate resources properly when you see a vet.*

- Creates false expectations among Veterans (and clinicians)
  - *They [Veterans] are told to come upstairs…'well why did they tell me to come up here?'... 'the doctor did not tell me all of that.'*

Challenge: Serve/Place Some Veterans

- Given existing programs, it can be difficult to place certain populations (e.g., families and children, SUD, sex offenders, medically complex and aging)
  - *We have aging veterans who have zero interest in stopping their use but need a higher level of care, and that is an absolute non-negotiable in a lot of the personal care homes or nursing homes or supportive living. They will not tolerate that at all.*

- Chronically homeless Veterans sometimes present challenges
  - *Our Vets are very resourceful; they know how to exist. Very few know how to live*.
  - Some Veterans are only willing to talk and work with specific staff, who are not always available
  - Stigma: some Veterans who are chronically homelessness may be uncomfortable receiving services in the same place as those who are “clean” etc.

- Veterans who are in need of clinical services but ineligible

Policy/Program Changes

- Some programs have become more flexible and useful, such as Grant Per Diem;
  - *Let's work on getting your resume, let's work on getting you some interviewing skills, let's work on being able to get up in the morning everyday and go to a group or something. … that is the important piece. We can not do that. They have to go to a Grant Per Diem, and the Grant Per Diems are getting more flexible, and it is easier to access them then it was in the past.*

- But elimination/loss of contract with local shelter Safe Haven created problems with placing Veterans

Mismatch: What HSCR Measures & Available Resources

- Clinicians administer HSCR and enter consults for Veterans who do not fit federal definition of homelessness/are not eligible for services;
  - *Just because you are living with your mom does not mean you are homeless… you are stably housed with someone according to HUD guidelines.*
  - *The assessment is not clear enough to the provider of what homelessness truly is; it does not follow the definition. I am sure that at one time it did not matter, but now, because of the way resources are set up, it does.*

- In light of workload and resources, these staff perceive greatest benefit in working with Veterans who are homeless or are going to be homeless imminently (tomorrow)
  - *If you become homeless, come and see us.*

- [Re-imagining how HSCR should read]: *'Where did you sleep last night?' 'At my mom's.' Okay, you are not homeless and it stops right there. You do not have to ask anything else.*

Suggestions to Improve HSCR Questions & Processes

- Change wording to better fit with federal definition of homelessness and available resources (HSCR should be better balanced with available resources, such that only Veterans who are literally homeless or going to be homeless tomorrow night are sent for consult)
- Drop the question “Would you like to talk to someone?”
- Better triage to stop or slow flow of Veterans who are in need of services other than housing and refer to appropriate resource– they are doing triage and providing services (“bring central intake back”)
- Formal training for clinicians
- Embed a social worker in the H-PACT

Needed Resources

- Transportation subsidies (tokens)
- Targeted services for Veterans who at risk but are ineligible for programs and services
- Case management for Veterans who need it (‘MHICM light’)
- Fiduciary management
- Housing for special populations
- More HUD-VASH vouchers and shelter for Veterans who are eligible

Summary

- Raises questions around how to deal with mismatch between what the HSCR picks up and federal policy
  - Change screener questions? Increase resources/staffing so Veterans who are identified as being at risk (beyond tomorrow) can be connected with appropriate services and resources?

- Policies and guidelines mean that literally homeless Veterans can be served/housed but some cycle back through, while many others at risk fall through the cracks and end up in the pipeline; so the pipeline is endlessly replenished

- Broader issues around screening for social determinants of health; how do screening questions keep up with changes in policy and programs?

Gaps & Questions

- Do VHA Homeless Program performance metrics drive who VA is willing or able to serve (e.g., literally or chronically homeless)?
  - Very specific population that appears eligible for services and rest of population with needs cannot get services until their homelessness becomes more acute.

References

Presentations

True, J. G., Cusack, M. C., Butler, A., Chhabra, M., Dichter, M. E., & Montgomery, A. E. (2017, June). *Inside the black box of screening for homelessness and housing instability: Perspectives from key stakeholders in the Department of Veterans' Affairs.* Poster presentation at AcademyHealth 2017 Annual Research Meeting, New Orleans, LA.

Works in Progress

Manuscript exploring expectations from screening for social determinants of health and the unintended consequences (Veterans, social workers, and clinicians)

Aim 2d

To understand, through interviews with VHA clinicians, how the HSCR is being administered, and the organizational factors that affect clinicians' ability to refer Veterans who screen positive to available services

Themes

- Interpretation and Administration of HSCR
- Referral Process
- Impact on Clinical Decision Making
- Role of Providers

Interpretation & Administration

- Most clinicians have adapted the reminder from its original form
  - *I usually screen with other questions before I get to the clinical reminder…I started asking those questions because when the reminder came out, it was clear that that was not the best yield from that question. I go through a series of shorter, easier to understand questions.*

- Providers found parts of the HSCR confusing
  - *If you were to read that question to them, they…wouldn't understand it the way it is written. I mean its just a long sentence. And people stop paying attention after 4 words or 5 words.*
  - *I think what is stable housing? You know, you have to have an interpretation of that. You know what I mean?*

Interpretation & Administration

- Patients typically respond well to being asked questions about housing
  - *I have had situations where they are wondering why I am asking. I usually then paraphrase and explain that the VA is interested in making sure that all Veterans [have] safe shelter. They are really wondering if you have a regular place to stay. When I explain that the VA has an interest in rubbing out homelessness among Veterans, they do generally get that.*
  - *They just never thought that us as the VA or, like, why does my doctor care if, if I'm living in instable housing.*

Interpretation & Administration

- Few providers probed into housing security routinely prior to the HSCR
  - *Not specifically [about housing insecurity]. Yeah, I mean I may ask who are you living with…sometimes, you know I always ask about employment and what are some things people do for employment or occupation.*
  - *Yeah, I don't think I really did….So before the reminder we really did not do any—at least not that I can think of- where we did any housing, any housing/homelessness screening.*

- Providers largely described addressing housing as not part of their training
  - *We're not really trained and we don't have [asking about housing] incorporated. Even though we're aware of many social determinants of health, homelessness hasn't really been part of [the] paradigm we've used.*

Interpretation & Administration

- The HSCR appeared to increase incorporation of housing situation into routine assessment
  - *I find the reminder actually very helpful even if I do not necessarily sit there and click through the reminder asking the prompts. It has prompted me to sort of incorporate it into what I normally do. I know I am going to have to click on it, so it has trained me to ask about it in my own way or whatever. It has been helpful.*

- And has increased recognition of housing instability
  - *I think I am more aware of it….I mean I just saw somebody today who I was seeing for an initial visit and when he said—he said something I cannot remember what it was - but I said so it sounds like your home situation is not very stable, and he said no, it is not. I said well we should try to find a way to try to fix that and find a place that is more secure, something that you can rely on.*

Referral Process

- Once screened, most providers found referral easy and could identify where to send patients
  - *I would tell the veteran to go to the eighth floor, and there's a homelessness person. And homeless outreach, and you can meet somebody there.*

- Unlike other "consults," providers often didn't know what happened once they referred patients
  - *It is a black box, they go up and they come back and either they have it or they do not. There usually is not a lot of notes on the chart about what happened. So you really do not know. You have to ask the patient what happened…Well he told me this and he told me that. I am here, I am there, I rejected it. So you do not get a lot of feedback.*

Referral Process

- Providers found that for many patient they referred, services were not available
  - *The expectations sent to us where we are trying to identify patients before they become homeless so we can help them and then they would reach the Homeless Outreach Office and be told that they are not homeless so they are not eligible for their assistance.*

- Most providers expressed need to have more social services directly within practices
  - *It would be nice to have someone embedded, in every service, where you do not have to walk anyone up, they would just be there or come to you while you are in that interaction.*

Impact on Clinical Decision Making

- Providers see lack of housing as a moment of crisis
  - *It is sort of 'antennae go up' when you hear somebody does not have stable housing. I think of that as one of the most fundamental...If you do not have shelter, you cannot do much else...It is like if somebody comes in with low blood pressure...it is a crisis.*

Impact on Clinical Decision Making

- Providers believe knowing patient's housing status affects ones clinical status
  - *If I knew somebody didn't have a stable home... I mean, so much of what we treat...diabetes, hypertension, their lifestyle that must incorporate not only medication and staying on medication, but food, exercise, depression. I mean…you have to have [housing]…*

- And impacts clinical decision making
  - *I think I am a little bit more cautious…I am a little bit more prone to do a physical exam…I don't like to use unnecessary tests but I may use them a little bit more freely in that population.*

Role of Providers

- However, there are mixed opinions on whether the role of physicians is to ask or address housing issues
  - *If you went through the 20 clinical reminders and really were open to hearing and bringing up all these points—suicide, depression, smoking, homeless—I mean, any one of those could tip a person over. So, it's unrealistic. And they should be really asked by different health professionals, not the physician. When you have time, face time with your doc, these are the things the doc really can make a clinical decision on. Not all this. It's in the wrong hands.*
  - *I don't think I should have a very big role in addressing homelessness to be perfectly honest with you. I mean, I think that the physician's role should be maybe help identify the problem, but I am not the best equipped professional to figure out what to do.*
  - *I think that VA should address homelessness and I think that the integration [of services] is great.*

Summary

- Providers see the health system as a place to address housing issues
- There are mixed opinions on whether providers should be the ones conducting screenings
- The presence of a screening tool has changed the way providers ask about housing
- Improvements need to be made with the referral process

Gaps & Questions

- Implementation of the HSCR did change practice and providers agree that it should continue to be administered, but who should do it?
  - Quantitative data from Aim 2a indicate it should be a provider other than the physician

References

Presentations

Chhabra, M., Cusack, M. C., Dichter, M. E., Butler, A., Montgomery, A. E., & True, J. G. (2017, April). Screening for homelessness: VA provider reflections on addressing a social determinant of health. Poster presentation at 2017 Annual Society of General Internal Medicine Meeting, Washington, DC.

Works in Progress

Chhabra, M., Sorrentino, A. E., Cusack, M. C., Dichter, M. E., Montgomery, A. E., & True, J. G. Screening for homelessness: VA provider reflections on addressing a social determinant of health.

Aim 3

(a) To evaluate the reliability and validity of the SSVF Instrument and Homelessness Risk Assessment (HRA) and to revise the instruments based on the results of these analyses

(b) To determine the total SSVF Instrument and HRA risk scores for respondents and whether it varies by individual characteristics and their responses to the HSCR

Psychometric Modeling

- For each of the 2 stages of the HRA:
  - Cronbach alpha was computed to estimate the internal consistency reliability of items
    - Based on tetrachoric correlations due to categorical data
  - Exploratory factor analysis was conducted to examine the inter-relationship among items
    - Oblimin rotation, weighted least squares using tetrachoric correlation matrix due to categorical data
  - Confirmatory factor analysis (CFA) was conducted to determine the construct validity of items
    - Delta parameterization, WLSMV estimator due to categorical data
- Analysis conducted on entire sample for stage 1 items
  - By screening subgroup membership: All, Homeless, At-risk, Negative
- Analysis conducted on imminent risk of literal homelessness sample only for stage 1 and stage 2 items

Internal Consistency Reliability (Cronbach alpha)

- Stage 2 items
  - Imminent Risk Only (N=685): .88
- Stage 1 + Stage 2 items
  - Imminent Risk Only (N=685): .88
- Stage 1 items: Entire sample
  - All (N= 2,853): .64
  - Homeless (N=1,839): .69
  - At-risk (N=906): .68
  - Negative (N=108): .66
- Stage 1 items
  - Imminent Risk Only (N=685): .64

Factor Analyses

- EFA
  - Results most consistent for the imminent risk of homelessness subsample
  - Results showed that items “hung together” essentially as arranged in the HRA instrument (e.g., disabilities/health, financial resources/needs, homeless history)
- CFA
  - Used EFA results as a rough guide
  - Overall model fit ranged from .60 to .90 across all models
  - Models had better fit with larger number of items and factors, and when only including the imminent risk of homelessness subsample
  - Final models including all items had fit indices in the .80 range with 6 factors
    - Homelessness history, financial resources/needs, disabilities/health, safety net, family structure, and other homelessness risk factors

HRA: Risk Score

14 items from the HRA closely map on to the targeting items of the SSVF Instrument; each item has an associated weight that can be combined into a total score (item, weight):

- Has moved because of economic factors two or more times in the past 60 days (3)
- Living in a hotel or motel not paid for by charitable organizations or by Federal, State, or local government programs (3)
- Living with friends or family, on a temporary basis (3)
- Being discharged from an institution and reintegrating into the community without a stable housing plan (3)
- History of homelessness as an adult, prior to any homeless episode occurring in the past 60 days (3)
- Households annual gross income is less than 30% of local Area Median Income for household size (3)
- Housing loss within 14 days (3)
- At least one dependent child under age 6 (3)
- At least one dependent child age 6-17 (2)
- Veteran returning from Iraq or Afghanistan (2)
- Applied for shelter or spent at least one night during the prior 60 days literally homeless (shelter, place not meant for human habitation, transitional housing for homeless persons) (2)
- Sudden and significant loss of income, including employment and/or cash benefits (2)
- Housing loss within 21 days (2)
- Rental and/or utility arrears (1)

HRA: Risk Score

- HRA Risk Score: M=7.64, SD=3.70, Min=1, Max=21
- HRA Risk Score was used to predict whether the Veteran was at imminent risk of homelessness using logistic regression
  - Odds ratio = 1.13, $p<.001$
  - For every 1 point increase of the HRA Risk Score, odds of imminent risk of homelessness increased by 13%

Summary

- For Veterans at imminent risk of homelessness, the HRA possessed good internal consistency reliability (reaching .88)
- EFA and CFA both provided evidence that items related to specific domains (eg, safety nets, risk factors, housing situation) hung together in clusters that matched the structure/organization of the HRA
  - No HRA items stood out as candidates for elimination or revision
- HRA Risk Score was effective in predicting imminent risk for homelessness
- The HRA offers utility in collecting information on individuals experiencing imminent risk of homelessness and can provide information on degree of risk

Gaps & Questions

References

Presentations

Fargo, J. D., Montgomery, A. E., Byrne, T. H., Cusack, M. C., Brignone, E., & Gundlapalli, A. (2017, November). Evaluating risk of homelessness among Veterans: Psychometric modeling of the Homelessness Risk Assessment Instrument. Oral presentation at 145th American Public Health Association Annual Meeting & Exposition, Atlanta, GA.

Works in Progress

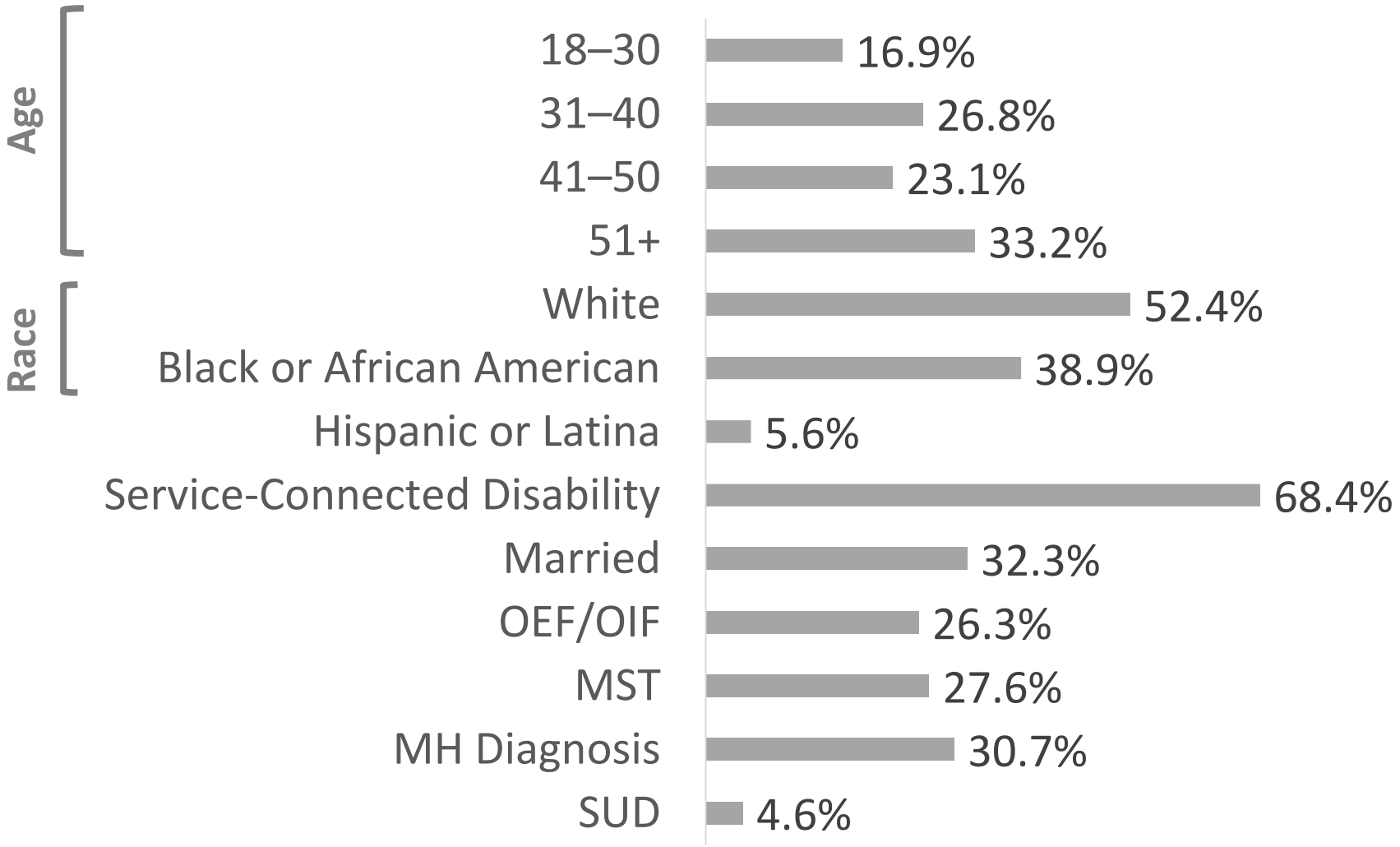
Plan to submit manuscript to *Health Services and Outcomes Research Methodology*

Examining the Role of Intimate Partner Violence in Housing Instability and Homelessness among Women Veterans

To identify the relationship between experience of recent IPV and housing instability among women Veterans using VHA medical record data

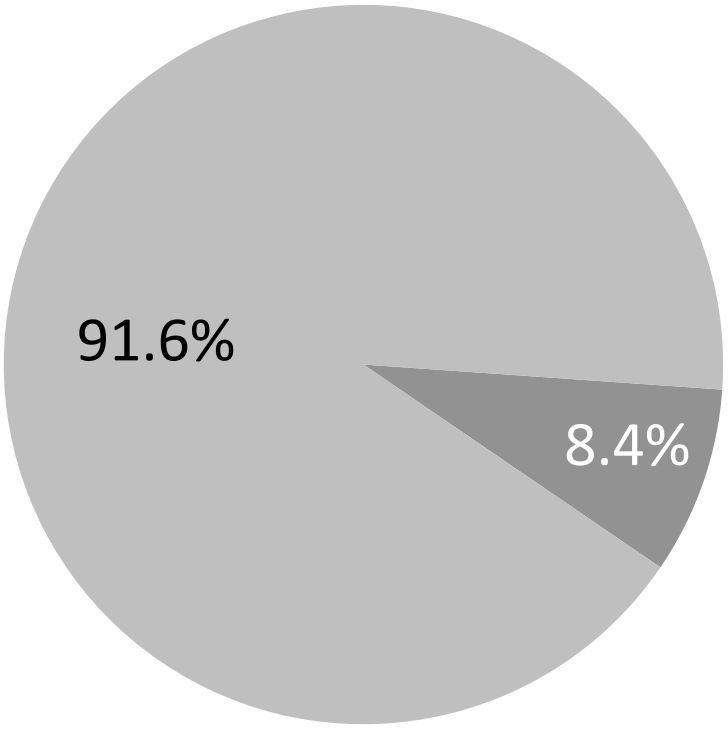
To understand the role of relationship factors, trauma, and interpersonal violence in contributing to and mitigating housing instability through examination of women Veterans' narrative accounts

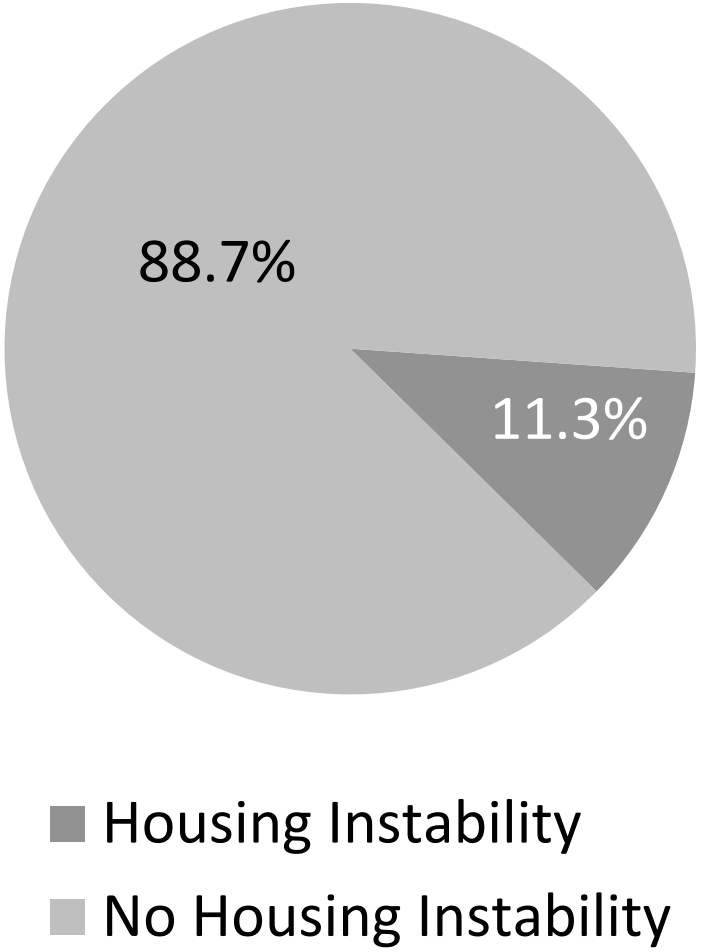
Study Cohort (N=8,427)



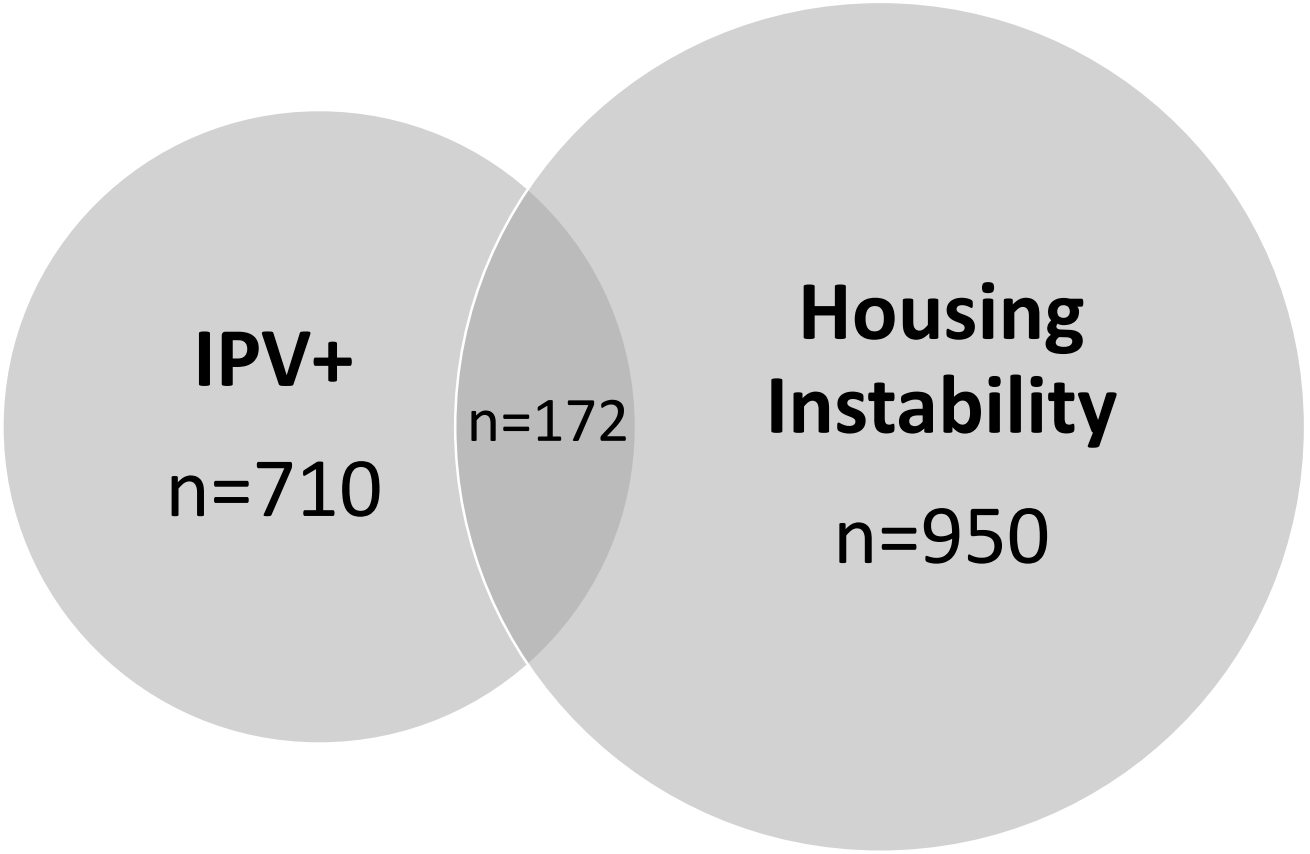
MST=Military Sexual Trauma; MH=Mental Health; SUD=Substance Use Disorder

Rates of IPV & Housing Instability





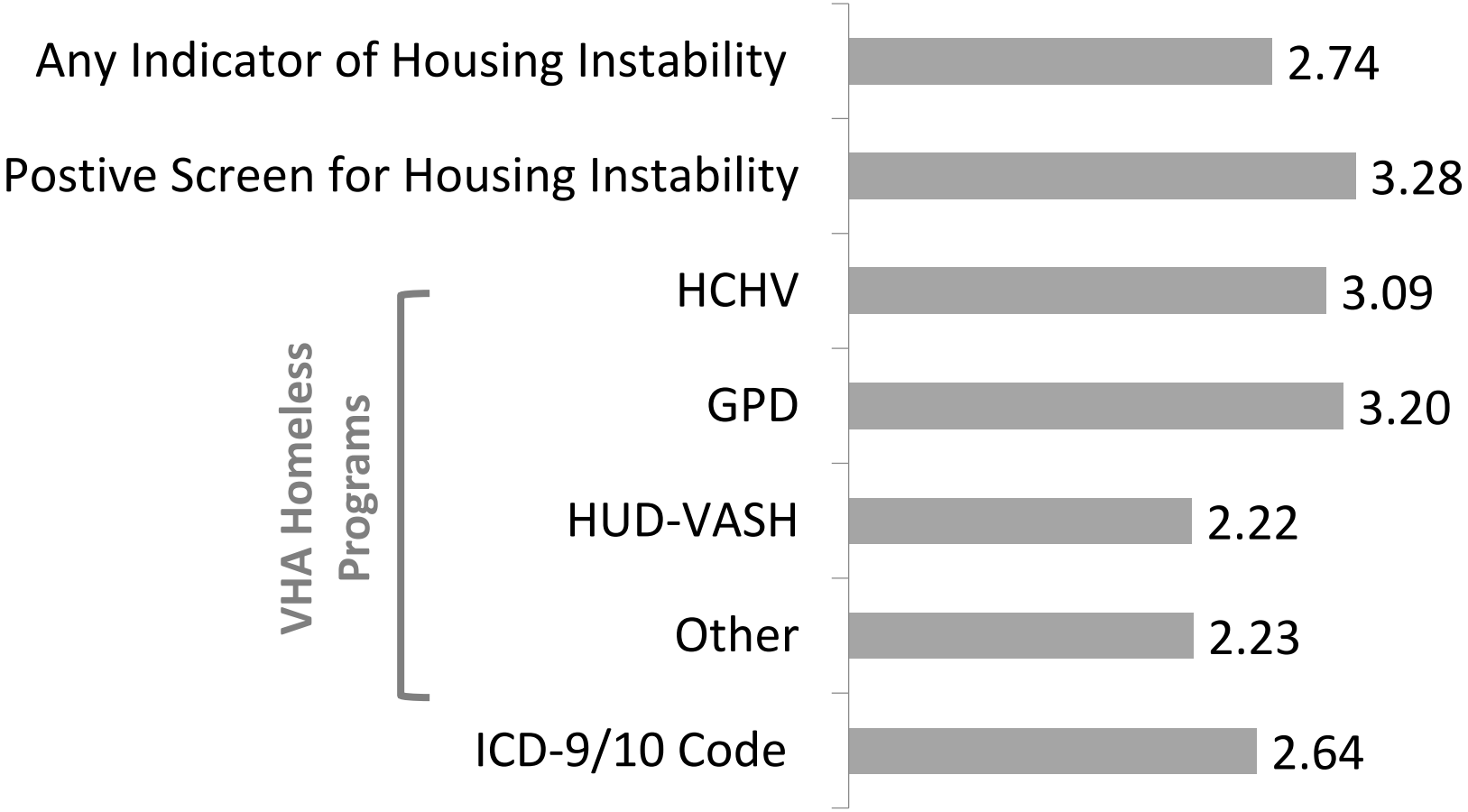
Overlap of IPV & Housing Instability



24.2% of women Veterans who screened IPV+ experienced housing instability

18.1% of women Veterans who experienced housing instability screened IPV+

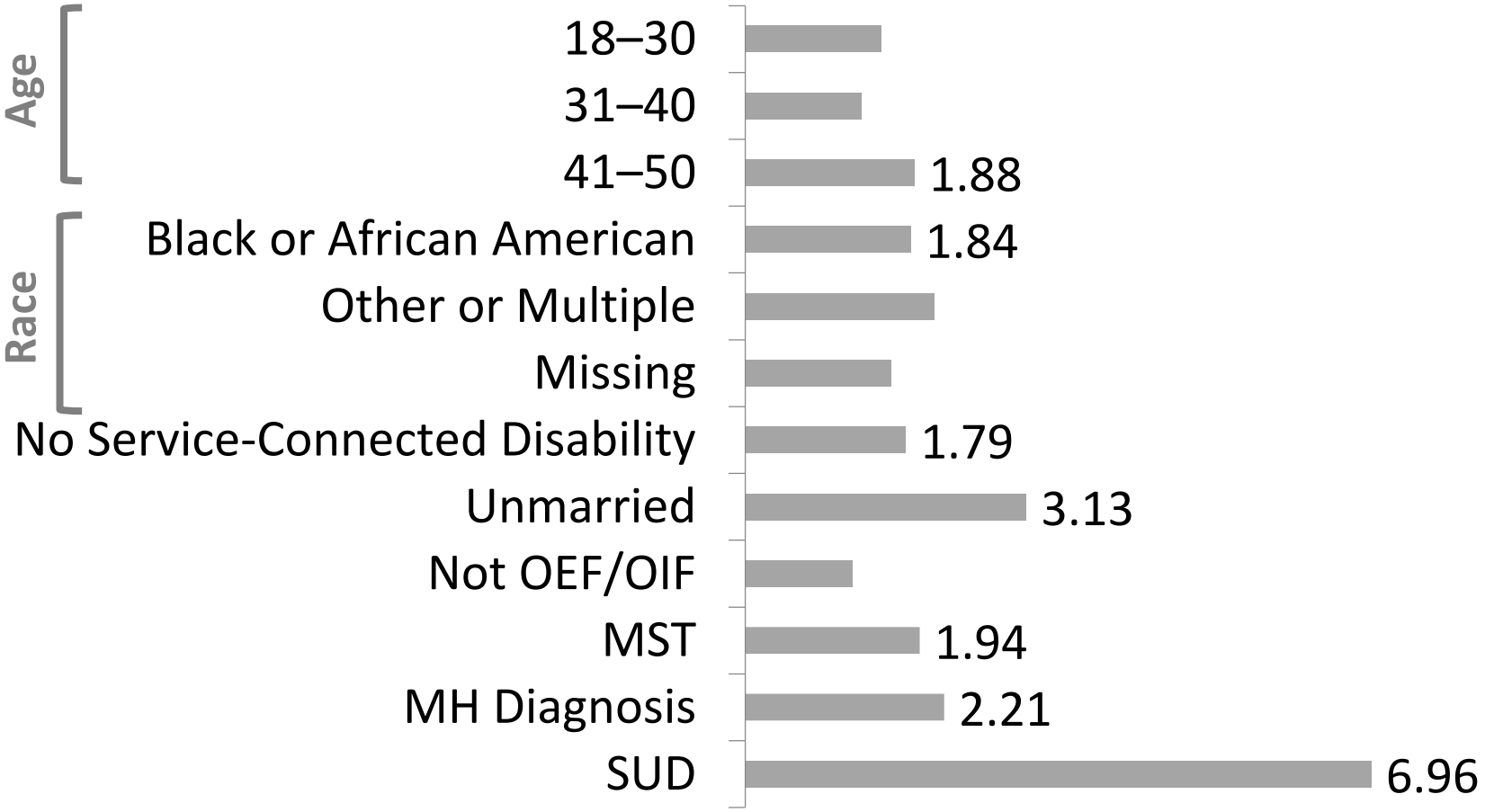
Odds of Housing Instability if IPV+



AOR control for age and race. Statistically significant at $p < .05$.
HCHV=Health Care for Homeless Veterans, GPD=Grant and Per Diem, HUD-VASH=U.S. Departments of Housing and Urban Development-VA Supportive Housing. Other VHA Homeless Programs include Compensated Work Therapy-Transitional Residence, Domiciliary Care for Homeless Veterans, Health Care for Reentry Veterans, Supportive Services for Veteran Families.

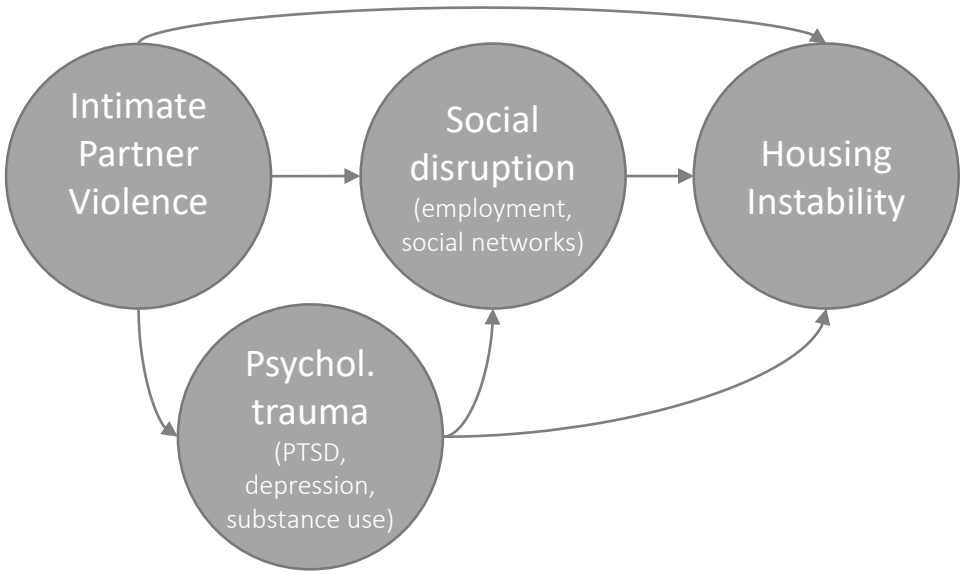
Correlates of Housing Instability

Among Women Veterans with IPV+ Screen



Reference group for age is 50+; reference group for race is White. AOR statistically significant at $p < .05$.

Theme 1: *IPV interacts with housing stability both directly and indirectly*



We had mutually come to the fact that we weren't going to be married any longer because he was abusive, mentally, emotionally, financially. … he said he just needed 30 days to leave the house. And so I went to my uncle's house… just to give him the time to move out; he did the opposite…He took all my personal information and taped it to the windows and the doors, like my Social [Security Number], my name, my height, my age, everything…He changed the locks on my house. And then he ultimately literally destroyed the house …I couldn't even live in the house.

Theme 2: *Experiences of IPV impact definitions of housing safety and security*

- Life-course, cumulative trauma experiences impact definitions and decisions: What is safe? What is stable?
- May be stable but not safe
- When away from abuse and seeking housing, considerations of what is acceptable are largely driven by safety concerns

All I wanna do is just move and be in a home where I don't have to worry about him walking in the door, not being destructive…I wanna be in a house where I don't have worry about going to sleep. I don't have to worry about what, is he gonna come in? I don't have to worry about what's gonna happen here today, what's gonna be said to me today, can I eat today, can I not eat today…[He would say to me] "This is my house. Get out. Go sit on the step, and I'll decide if I'll let you back in today." That type of stuff. So I just wanna be in a position where that's not the case anymore. I don't have to get out. I don't have to worry about not eating.

Theme 3: *IPV may be a barrier to accessing housing services and other supports*

- Need for secrecy, confidentiality
- Partner interference with service access, social networks
- Perceptions about definitions of homelessness
- Shame, stigma about abuse

While [the housing agency was] helping me, I still had to go home to my abusive husband…I told him I was going to anger managment...Eventually I did have to tell him and that was scary.

Summary

- Nearly 1 in 4 women Veterans who experienced past-year IPV are potentially unstably housed
  - Interventions to assess and address IPV and housing instability should be coordinated, as appropriate
  - Providers should assess patients' safety needs and attend to related concerns
- Women Veterans experiencing IPV with less access to resources through VA compensation or spouse are at increased risk of housing instability
  - Temporary financial assistance, through programs such as SSVF, may prevent housing instability among women Veterans leaving abusive partner
- IPV, MST, SUD, and MH significantly associated with housing instability → women Veterans with multiple traumas are particularly vulnerable
  - MH, SUD, and trauma services may need to be coordinated with housing
  - Not clear which comes first, but likely interrelated; qualitative research may help to elucidate pathways and interactions

Gaps & Questions

References

Presentations

Clubb, B., Caplan, J., & Montgomery, A. E. (2018, May). DV and IPV: A Veteran perspective. Learning institute at the 2018 National Coalition for Homeless Veterans Annual Conference, Washington, DC.

Dichter, M. E., & Montgomery, A. E. (2018, January). Examining the role of intimate partner violence in housing instability among women Veterans. Oral/virtual presentation at VA National Center on Homelessness Among Veterans Connecting Research to Practice.

Dichter, M. E., & Montgomery, A. E. (2018, January). Examining the role of intimate partner violence in housing instability among women Veterans. Oral presentation at 22nd Annual Conference of the Society for Social Work and Research, Washington, DC.

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Publications

Dichter, M. E., Montgomery, A. E., Sorrentino, A. B., Cusack, M. C., Haywood, T., Medvedeva, E., Roberts, C. B., Bellamy, S., & True, J. G. (2018, January). Research brief: Examining the role of intimate partner violence in housing instability and homelessness among women Veterans. Philadelphia, PA: VA National Center on Homelessness Among Veterans.

Montgomery, A. E., Sorrentino, A. E., Cusack, M. C., Bellamy, S. L., Medvedeva, E., Roberts, C. B., & Dichter, M. E. (2018). Recent intimate partner violence and housing instability among women Veterans. American Journal of Preventive Medicine, 54(4), 584–590.

Works in Progress

Yu, B., Montgomery, A. E., True, J. G., Cusack, M. C., Sorrentino, A. E., Chhabra, M., & Dichter, M. E. The intersection of interpersonal violence and housing instability: Perspectives from women Veterans.

Future Work

Dissemination

- List of work completed to date, pilot studies
- List of proposed papers
- Development of materials for operations partners
  - White paper summarizing study results for VHA Homeless Programs Office
- Development of materials for other partners
  - Social Interventions Research & Evaluation Network
  - CMMS Accountable Health Communities Model

Additional Data Collection & Analysis

- Interview staff at high-performing sites (i.e., sites with high % of HSCR+ Veterans connected with services, resolution of housing instability) to understand effective screening practices and responses

Future Grants: NCHAV Pilot

- Pilot education materials for Veterans with HSCR+

Future Grants: IIR/QUERI

Tailor HSCR

- Targeting
  - Universal
  - Risk-stratified
- Language
  - Tailor to policy or eligibility
- CON: Too difficult to make changes to medical record

Tailor System Response

- Refine feedback loop post-HSCR+
- Develop centralized screening, triaging for social determinants of health
- Training for HSCR administrators and responders
- Develop case management or peer support to assist with navigating resources (potential adaptation of existing best practices)
- PRO: More feasible to change the response to HSCR+